South Carolina Department of Health and Human Services

Request for Verification from South Carolina Retirement Systems

To: South Carolina Retirement Systems
Benefit Department
P. O. Box 11960 – Capitol Station
Columbia, South Carolina 29211

Date: _____

From: _____, Medicaid Worker

_____DHHS

Telephone Number of Medicaid Worker:

_____

The individual named below has applied for (or is receiving) Medicaid benefits.

Name of Medicaid Applicant/Beneficiary: _____

Address of Medicaid Applicant/Beneficiary:

Budget Group Number: _____ Social Security Number: _____

Retirement Number: _____

In order that we may determine the individual's initial or continued Medicaid eligibility, please provide the information requested below. Attached is a signed release from the applicant/beneficiary or the authorized representative authorizing the Department of Health and Human Services to receive this information.

<table>
<tr><td>Effective Date of Retirement:</td><td>Current Entitlement Amount:</td><td>Current Benefit Amount:</td></tr>
<tr><td colspan="2">If benefit reduction occurred, when?</td><td>Entitlement Amount at Time of Reduction:</td></tr>
<tr><td colspan="3">Dates and Percentages of Cost-of-Living Increases Granted Since the Reduction Occurred:

Date: _____ Percentage: _____

Date: _____ Percentage: _____

Date: _____ Percentage: _____</td></tr>
<tr><td>Signature of Official of South Carolina Retirement Systems:</td><td>Telephone Number:</td><td>Date:</td></tr>
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